CANADIAN BLOOD SERVICES

TRALI Patient Data

Please forward the original of this form to your local Canadian Blood Services Centre Medical Office for reporting. Send a photocopy with the patient samples.
(All fields must be completed before laboratory tests are performed)

1. CONTACT INFORMATION		
Patient Name:		
Unique identification number:		
DOB (dd/mmm/yyyy):	Gender: Male ☐ Female ☐	
TRALI date (dd/mmm/yyyy) :	Time :	
Physician :	Telephone :	
Institution :	CBS Centre :	

2. INCLUSION CRITERIA: must fit a, b AND c, otherwise TRALI investigation is NOT warranted			
a) Transfusion within 6 hours of TRALI	Yes ☐ No ☐		
b) New CXR findings	Yes ☐ No ☐ N/A ☐	Bilateral infiltrate Yes ☐ No ☐ If no, describe:	
c) Hypoxemia	O_2 sat < 90 %	Yes ☐ No ☐ Unknown ☐	
	or pO_2 < 60 mm Hg	Yes ☐ No ☐ Unknown ☐	
	or PaO_2/FIO_2 < 300 mm Hg	Yes ☐ No ☐ Unknown ☐	

3. CLINICAL IMPRESSION OF TRALI REACTION						
Based on clinical impression, grade:						
Suspicion of TRALI reaction :	Highly unlikely 0 ☐	1 ☐	2 ☐	3 ☐	4 ☐	Highly likely 5 ☐
Severity of TRALI reaction :	Mild ☐	Moderate ☐	Severe ☐	Life threatening ☐		

4. PATIENT HISTORY			
Previous transfusions	Yes ☐ No ☐ Unknown ☐		Patient ABO:
Pregnancies/miscarriages	Yes ☐ No ☐ Unknown ☐	Number:	
Describe principal diagnosis:			
Underlying clinical conditions (mark all that apply):		Infection ☐	Inflammatory conditions ☐
Surgery: Cardiopulmonary bypass ☐		Trauma ☐	Massive transfusion ☐
Surgery: Other ☐ Describe:		Chemotherapy ☐	Other:

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PATIENT'S NAME: _____

5. CLINICAL SIGNS AND LABORATORY RESULTS

Fever (1-2ºC increase) Yes ☐ No ☐ Chills/rigors Yes ☐ No ☐ BP before transfusion:

Dyspnea Yes ☐ No ☐ Other: BP at time of TRALI:

Pulmonary edema Yes ☐ No ☐

If pulmonary edema **Cardiogenic** ☐ **Non-cardiogenic** ☐ **Unknown** ☐

If non-cardiogenic, how determined:

BNP peptide: Date pre: Date post:

Diuretics Yes ☐ No ☐ Effective? Yes ☐ No ☐

LV function Normal ☐ Decreased ☐ Unknown ☐ How determined:

Hgb: Blood Cultures: Pos ☐ Neg ☐ Not done ☐

WBC: % Lymphocytes: % Neutrophils: Organism:

6. TREATMENT

Mechanical ventilation Yes ☐ No ☐ Duration (hrs):

Supplemental Oxygen (no intubation) Yes ☐ No ☐

Other:

7. OUTCOME AT TIME OF TRALI REACTION REPORT

Ongoing Yes ☐ No ☐ Time since onset (hrs):

Recovered Yes ☐ No ☐ Time to recovery (hrs):

Deceased Yes ☐ No ☐ Date: (yyy-mm-dd):

If deceased: Death due to TRALI? Yes ☐ Contributing ☐ Uncertain ☐ No ☐

If no or uncertain, indicate cause of death:

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8. TRALI - IMPLICATED PRODUCTS/ UNITS (transfused within 6 hr of reaction)							
Product Code	ABO	Donation/Pool Number	Date of Transfusion (dd/mmm/yyyy)	Time of transfusion (start)	Time of transfusion (end)	Volume transfused (<25%, 25%, 50%, 75%, all)	Age of Product (days)

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9. HOSPITAL SAMPLE COLLECTION FOR PATIENT INVESTIGATION :

Collected by:

Name: _____ Initials: _____ Date (dd/mmm/yyyy): _____

a) PATIENT samples must be labelled with the following information which matches exactly the information on the form:

- First and last name
- Unique patient identification number (preferably the personal provincial health number)
- Date of collection

Pre-TRALI	1 x 7mL separated serum (not collected in SST gel)	Send frozen
Post-TRALI	1 x 7mL separated serum (not collected in SST gel)	Send frozen
	and 1 x 7mL **unopened** EDTA (for DNA testing)	Send at 4ºC

NOTIFY BEFORE SAMPLE SHIPMENT:

Platelet Immunology Lab
Phone: 204-789-1152
Fax: 204-789-1186

SHIP SAMPLES IMMEDIATELY TO:

Platelet Immunology Lab
Canadian Blood Services
777 William Ave
Winnipeg, MB
R3E 3R4

or

To your nearest CBS Centre

NOTE:
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